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10 **BEFORE THE**
RESPIRATORY CARE BOARD
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

12 In the Matter of the Accusation Against:

Case No. R-2054

13 KELLY L. MACNEIL
14 13320 Olive Tree Lane
Poway, CA 92064

A C C U S A T I O N

15 Respiratory Care Practitioner
16 License No. 22486

17 Respondent.

18
19 Complainant alleges:

20 **PARTIES**

21 1. Stephanie Nunez (Complainant) brings this Accusation solely in her
22 official capacity as the Executive Officer of the Respiratory Care Board of California,
23 Department of Consumer Affairs.

24 2. On or about August 2, 2002, the Respiratory Care Board issued
25 Respiratory Care Practitioner License No. 22486 to KELLY L. MacNEIL (Respondent). The
26 Respiratory Care Practitioner License was in full force and effect at all times relevant to the
27 charges brought herein and will expire on November 30, 2007, unless renewed.

28 ///

JURISDICTION

3. This Accusation is brought before the Respiratory Care Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 3710 of the Code states: “The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter [Chapter 8.3, the Respiratory Care Practice Act].”

5. Section 3718 of the Code states, in pertinent part: “The board shall issue, deny, suspend, and revoke licenses to practice respiratory care as provided in this chapter.”

6. Section 3750 of the Code states, in pertinent part:

“The board may order the denial, suspension or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:

“... .

“(f) Negligence in his or her practice as a respiratory care practitioner.

“(g) Conviction of a violation of any of the provisions of this chapter or of any provision of Division 2 (commencing with Section 500), or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter or of any provision of Division 2 (commencing with Section 500).

“... .

“(k) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any patient, hospital, or other record.

“(l) Changing the prescription of a physician and surgeon, or falsifying verbal or written orders for treatment or a diagnostic regime received, whether or not that action resulted in actual patient harm.

“... .

“(o) Incompetence in his or her practice as a respiratory care practitioner.

1 “(p) A pattern of substandard care.”

2 7. Section 3755 of the Code states:

3 “The board may take action against any respiratory care practitioner who is
4 charged with unprofessional conduct in administering, or attempting to administer, direct
5 or indirect respiratory care. Unprofessional conduct includes, but is not limited to,
6 repeated acts of clearly administering directly or indirectly inappropriate or unsafe
7 respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or
8 monitoring techniques, and violation of any provision of Section 3750. The board may
9 determine unprofessional conduct involving any and all aspects of respiratory care
10 performed by anyone licensed as a respiratory care practitioner.”

11 8. California Code of Regulations (“CCR”), title 16, section 1399.370, states:

12 “For the purposes of denial, suspension, or revocation of a license, a crime or act
13 shall be considered to be substantially related to the qualifications, functions or duties of
14 a respiratory care practitioner, if it evidences present or potential unfitness of a licensee to
15 perform the functions authorized by his or her license or in a manner inconsistent with the
16 public health, safety, or welfare. Such crimes or acts shall include but not be limited to
17 those involving the following:

18 “(a) Violating or attempting to violate, directly or indirectly, or assisting or
19 abetting the violation of or conspiring to violate any provision or term of the Act.

20 “. . .”

21 COST RECOVERY

22 9. Section 3753.5, subdivision (a) of the Code states, in pertinent part:

23 “In any order issued in resolution of a disciplinary proceeding before the board,
24 the board or the administrative law judge may direct any practitioner or applicant found to have
25 committed a violation or violations of law to pay to the board a sum not to exceed the costs of the
26 investigation and prosecution of the case. . . .”

27 10. Section 3753.7 of the Code states:

28 “For purposes of the Respiratory Care Practice Act, costs of prosecution shall

1 include attorney general or other prosecuting attorney fees, expert witness fees, and other
2 administrative, filing, and service fees...."

3 11. Section 3753.1 of the Code states, in pertinent part:

4 "(a) An administrative disciplinary decision imposing terms of probation may
5 include, among other things, a requirement that the licensee-probationer pay the monetary costs
6 associated with monitoring the probation. "

7 FIRST CAUSE FOR DISCIPLINE

8 (Negligence and Incompetence)

9 12. Respondent is subject to disciplinary action under section 3750, as defined
10 by sections 3750(f), 3750(o) and 3750(g) of the Code, and CCR, title 16, section 1399.370(a), in
11 that she was negligent and incompetent in the care and treatment she provided to two neonate
12 patients identified by medical record numbers as #01-44-40-33 and #01-36-82-28. The
13 circumstances are as follows:

14 **Patient Medical Record # 01-44-40-33**

15 A. On or about November 2, 2005, Respondent provided care
16 and treatment to neonate patient #01-44-40-33 at the Intensive Care Unit of the
17 Sharp Mary Birch Hospital for Women. By physician's order, patient #01-44-
18 4033 was in the intensive care and was on a Drager Babylog 8000 ventilator¹. At
19 about 1605, Respondent turned down the Drager Babylog 8000 ventilator flow
20 from "8 lpm" to "2 lpm" in order to administer a nebulizer treatment to patient
21 #01-44-40-33. Respondent also changed the patient's (#01-44-40-33) ventilator
22 to a respiratory rate of 55 without a physician's order or knowledge. Upon
23 completion of the nebulizer treatment, Respondent failed to turn the flow back up
24 to "8 lpm". Approximately 45 minutes later, Respondent went back to the

26 1. Drager Babylog 8000 - A conventional ventilator used on neonates and works the same
27 as any other conventional ventilator, except it works on the premise of volume control only. It
28 has the ability to compensate for additional flow introduced into the system. The flow setting
on the Drager is normally set at 6 - 8 for a neonate.

1 patient's (#01-44-40-33) bedside to perform a routine ventilator check and
2 without verification, documented that the ventilator flow was at "8 lpm".

3 B. Respondent's failure to turn the ventilator flow to "8 lpm" caused
4 the patient's (#01-44-40-33) PCO₂² to rise to an alarming rate of 111 and the
5 patient (#01-44-40-33) to go into acute distress. However, Respondent was
6 unable to understand the consequences of her failure and failed to take any
7 corrective action. The patient's (#01-44-40-33) acute distress resulted in a
8 physician's intervention and in the course of the intervention another therapist
9 (Therapist R.J) noticed the settings on the ventilator had the flow turned down to
10 2 lpm and immediately turned the flow back up to 8 lpm. Therapist R.J. then
11 informed Respondent of her failure to turn the flow back up after administering
12 the nebulizer treatment.³ When Respondent was asked why she charted the flow
13 at 8 lpm, Respondent stated, "I think I charted what I wanted to see".

14 **Patient Medical Record #01-36-82-28**

15 C. Infant patient #01-36-82-28 was born with severe
16 Hydrocephalus, non-immune and had severe pulmonary hypertension. On or
17 about August 18, 2004, by a physician's order, patient #01-36-82-28 was placed
18 on a high frequency oscillator ventilator and placed on Nitric Oxide ("iNO") 20
19 ppm (parts per million). On or about August 19, 2004, without a physician's
20 order or knowledge, Respondent made a decision to discontinue iNO therapy.
21 Respondent did not remember how to turn off the iNO and so she asked for
22 assistance from another therapist, and turned off the gas to withdraw the iNO.

23
24 2. PCO₂ - The partial pressure of carbon dioxide measured in millimeters of mercury,
mmHg. Normal PCO₂ between 35-45.

25 3. On October 20, 2005, (just 12 days earlier to the incident involving Patient One) while
26 rendering treatment to another infant patient, Respondent turned the flow knob off and failed to
27 remember to turn it back on. Another therapist found the error and turned the flow knob back
28 on. Respondent was counseled by her employer for this incident and was asked to attend an in-
service to further her knowledge and also to place a sticker on the flow knob to use as a
reminder to turn the flow back up after giving a treatment.

1 After turning off the iNO, patient #01-36-82-28 started to desaturate, and
2 Respondent turned the iNO back up to 20 ppm. Respondent failed to chart that
3 she discontinued the patient's (#01-36-82-28) iNO. When Respondent asked why
4 she turned off the iNO, Respondent stated she was just "trialing the baby off" and
5 would have requested a physician's order if it had worked.

6 13. Respondent's respiratory license is subject to disciplinary action for
7 negligence and incompetence, in violation of Code sections 3750(f) and 3750(o), in that:

8 A. The allegations in paragraph 12 are here realleged as
9 though fully set forth.

10 **Patient Medical Record #01-44-40-33**

11 B. Respondent failed to turn the ventilator flow back up after
12 turning it down while administering a nebulizer treatment to this patient.

13 C. Respondent failed to recognize that the patient's acute distress was
14 due her failure to decrease in the ventilator flow.

15 D. Respondent failed to assess and troubleshoot to determine
16 the patient's ventilator problem.

17 E. Respondent failed to verify the settings before charting and
18 charted incorrectly for the patient;

19 F. Respondent changed the patient's ventilator to a respiratory
20 rate of 55 without a physician's order or knowledge;

21 **Patient Medical Record #01-36-82-28**

22 G. Respondent discontinued this patient's iNO without a
23 physician's order or knowledge; and

24 H. Respondent failed to chart that she discontinued giving the
25 patient's iNO therapy.

26 **SECOND CAUSE FOR DISCIPLINE**

27 (Changing a Physician's Order)

28 14. Respondent is subject to disciplinary action under section 3750, as defined

1 by 3750(l), in providing care and treatment to two neonate patients, Respondent discontinued
2 iNO therapy of patient #01-36-82-28 without a physician's order or knowledge, and changed the
3 respiratory rate to 55 of patient #01-44-40-33 without a physician's order or knowledge, as more
4 particularly described in paragraph 12, above, which is incorporated by reference as if fully set
5 forth herein.

6 THIRD CAUSE FOR DISCIPLINE

7 (Falsifying or making grossly incorrect entries in any patient record)

8 15. Respondent is subject to disciplinary action under section 3750, as defined
9 by 3750(k) of the Code, in that in the course of providing care and treatment to two neonate
10 patients, Respondent falsely charted the ventilator flow was at 8 lpm; failed to chart she failed to
11 turn the ventilator flow back up after administering the nebulizer treatment; failed to chart that
12 she changed the respiratory rate to 55; and failed to chart that she discontinued the iNO therapy,
13 as more particularly described in paragraph 12, above, which is incorporated by reference as if
14 fully set forth herein.

15 FOURTH CAUSE FOR DISCIPLINE

16 (Pattern of Substandard Care)

17 (Unprofessional Conduct)

18 16. Respondent is subject to disciplinary action under Code sections 3755 and
19 3750, as defined by 3750(p), in that she demonstrated a pattern of substandard care and
20 unprofessional conduct in her care and treatment of two neonate patients as more particularly
21 described in paragraphs 12 - 15 above, which are incorporated by reference as if fully set forth
22 herein.

23
24 PRAYER

25 WHEREFORE, Complainant requests that a hearing be held on the matters herein
26 alleged, and that following the hearing, the Respiratory Care Board issue a decision:

27 1. Revoking or suspending Respiratory Care Practitioner License No. 22486,
28 issued to KELLY L. MacNEIL;

1 2. Ordering KELLY L. MacNEIL to pay the Respiratory Care Board the costs
2 of the investigation and enforcement of this case, and if placed on probation, the costs of
3 probation monitoring;

4 3. Taking such other and further action as deemed necessary and proper.

5 DATED: February 2, 2007

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8 Original signed by Liane Zimmerman for:
9 STEPHANIE NUNEZ
10 Executive Officer
11 Respiratory Care Board of California
12 Department of Consumer Affairs
13 State of California
14 Complainant
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